KANSAS DEPARTMENT ON AGING

HOME AND COMMUNITY BASED SERVICES FOR THE FRAIL ELDERLY
PHYSICIAN/RN STATEMENT FOR CUSTOMER DIRECTED ATTENDANT CARE
(Health Maintenance Activities)

PART I: COMPLETED BY THE CUSTOMER OR CASE MANAGER

Customer Name _____ Address _____

City _____ Zip _____ Phone #_____ DOB ____/____/____

SS # _____

Person supervising or directing the customer's Medication Set-up or Health Maintenance Activities:

☐ Customer

OR

☐ Customer's Authorized Representative _____

Relationship _____ Phone # _____

The customer has been assessed and found eligible for Home and Community Based Services for the Frail Elderly. The customer or his/her authorized representative has chosen to self-direct Attendant Care services that are classified as Medication Set-up or Health Maintenance Activities. Medication Set-up and Health Maintenance Activities include the following tasks:

_____

_____

_____

☐ Attached you will find a Customer Service Worksheet that addresses the customer's needs and outlines who will assist the customer.

☐ Attached is documentation from the case manager (only check if applicable).

PART II: COMPLETED BY THE PHYSICIAN OR REGISTERED NURSE

Please check one:

☐ I have read the information provided to me and in my judgement the person listed in the box above **is able** to supervise and direct the customer's Medication Set-up or Health Maintenance Activities.

☐ I have read the information provided to me and in my judgement the person listed in the box above **is not able** to supervise and direct the customer's Medication Set-up or Health Maintenance Activities for the following reasons:

_____

_____

X_____ **X**_____

Signature of Customer's attending Physician or Registered Nurse Date